STATE OF MICHIGAN

IN THE SUPREME COURT

ESTATE OF DANIEL D. JILEK, Deceased by JOY A. JILEK, Personal Representative,	Docket No. 141727
Plaintiff-Appellee,	Court of Appeals No. 289488
-vs-	
CARLIN C. STOCKSON, M.D. and EPMG of MICHIGAN, P.C. a Michigan corporation, jointly and severally,	Washtenaw County Circuit Court No. 05-268-NH
Defendants-Appellants.	

141727
reply

DEFENDANTS-APPELLANTS' REPLY BRIEF SUBMITTED PURSUANT TO THE COURT'S SEPTEMBER 20, 2011 ORDER

MARK GRANZOTTO (P31492)
Mark Granzotto, P.C.
225 South Troy Street, Ste. 120
Royal Oak, Michigan 48067
248-546-4649
Attorneys for Plaintiff-Appellee

PETER A. DAVIS (P12563)
CAROL A. KUHNKE (P55348)
Davis & Kuhnke, P.C.
405 North Main Street
Ann Arbor, Michigan 48104
734-663-2233
Attorneys for Plaintiff-Appellee

NOREEN L. SLANK (P31964)
Collins Einhorn Farrell & Ulanoff, P.C.
4000 Town Center, Suite 909
Southfield, Michigan 48075
248-355-4141
Attorneys for Defendants-Appellants

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ARGUMENT I: The proofs at trial clearly support the trial court's decision that family medicine sets the standard of care.

Plaintiff's recently-filed brief embraces the approach of the Court of Appeals majority. Plaintiff urges applying an emergency medicine standard of care as if this case were examining the sufficiency of Dr. Sama's affidavit of merit (AOM). But that *isn't* what this case is about. Tracking the error of the Court of Appeals majority, plaintiff ignores the proofs at trial and instead recounts the parties' early dispute about whether affirmative defenses aimed at plaintiff's AOM were sufficiently detailed. Instead of coming to terms with the trial record, as plaintiff must, plaintiff tries to freeze the examination of the *Woodard v Custer*, 476 Mich 545, 560 (2006) "one most relevant standard of practice or care" issue at the pre-trial stage. That's why plaintiff discusses signs in Maple Urgent Care's parking lot, listings on the hospital's website (never seen by the defendants prior to this lawsuit) and medical records and signatures referencing "emergency." Plaintiff barely even mentions the testimony of the defense family medicine experts. Each of them, as well as Dr. Stockson, provided detailed support for a family medicine standard of care.[1] Each of them testified that Dr. Stockson met that standard during her treatment of Mr. Jilek in the urgent care setting.

What matters at the AOM stage is whether "the plaintiff's attorney reasonably believes" the expert "meets the requirements for an expert witness under [600.2169]." MCL 600.2912d(1). In *Grossman v Brown*, 470 Mich 593, 598-599 (2004), this Court contrasted the statutory rigors of providing suitable expert trial testimony with the more flexible inquiry at the AOM stage:

> With regard to the first stage, under MCL 600.2912d(1), a plaintiff is required to file with the complaint an affidavit of merit signed by an expert who the plaintiff's attorney *reasonably believes* meets the requirements of MCL 600.2169. With regard to the second stage, the trial, MCL 600.2169(1) states

[1] Dr. Stockson also testified she has never worked in an emergency room and is not board-eligible in emergency medicine. Vol 3 of 7, p 230; Vol 6 of 7, pp 162, 164-165.

> that "a person *shall not* give expert testimony . . . unless the person" meets enumerated qualifications . . . .
>
> The Legislature's rationale for this disparity is, without doubt, traceable to the fact that until a civil action is underway, no discovery is available. See MCR 2.302(A)(1). Thus, the Legislature apparently chose to recognize that at the first stage, in which the lawsuit is about to be filed, the plaintiff's attorney only has available publicly accessible resources to determine the defendant's board certifications and specialization. At this stage, the plaintiff's attorney need only have a *reasonable belief* that the expert satisfies the requirements of MCL 600.2169. See MCL 600.2912d(1). (Emphasis added).

To rule "as a matter of law, the proper standard of care was that for [sic] emergency medicine specialists"[2] the Court of Appeals majority had to: (1) ignore the testimony of defense experts Drs. Kushner and Ruoff, (2) ignore Dr. Stockson's testimony, and (3) even ignore some of the testimony of plaintiff's expert Dr. Birrer (boarded in both family and emergency medicine) who equated the two specialties as he testified on standard of care.[3] The majority also ignored the rules that govern appellate review of trial court decisions. Decisions about the "one most relevant" standard of care are subject to an abuse of discretion standard of review. *Woodard, supra* at 557. The trial court's ruling is fully supported by the evidence submitted at trial and did not "result in an outcome falling outside the principled range of outcomes." *Id.*

a. No *Woodard*-impermissible "hybrid" standard of care was applied.

The plaintiff claimed, and the Court of Appeals agreed, that the trial court's jury instruction violated *Woodard's* "one most relevant" directive by identifying the standard of care as that of a doctor "specializing in family practice and working in an urgent care center."[4] According to plaintiff, the only *Woodard*-compliant instruction would need to leave out the phrase "working in an urgent care center." There is no board certification in urgent care.[5]

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[2] Tab B, Application for Leave, Court of Appeals majority opinion, p 7.
[3] Vol 4 of 7 (Birrer), p 38.
[4] Vol 7 of 7, p 73.
[5] Vol 4 of 7 (Birrer), p 34.

Therefore, referencing urgent care cannot amount to a two-specialty instruction to the jury. "[I]n an urgent care center" refers to a place, not a medical specialty.

Woodard turned our jurisprudence away from a path that would have required an expert's specialties to match every one of a defendant's specialties. "Although specialties and board certificates must match, not *all* specialties and board certificates must match." *Woodard* at 558. MCL 600.2169 assures that the expert testimony is about ""the *appropriate* standard of practice or care'" not "an inappropriate or irrelevant standard of medical practice or care." *Woodard* at 559. *Woodard* does not prevent grounding the practice of the specialty to a particular place, especially where, as here, the place where Mr. Jilek was treated became such a focal point for *both* sides. And, as Judge Bandstra pointed out in dissent, if anything, the urgent case language held Dr. Stockson to a "higher standard of care because of the place in which she practiced her family medicine."[6]

Additionally, consider whether deletion of the phrase "working in an urgent care center" would have caused the jury to understand the instruction any differently. That is the only place Dr. Stockson practiced. She didn't practice in an emergency room. She also didn't practice in a traditional family practice that serves a particular stable patient population, requires a patient to make an appointment, and keeps shorter office hours. And *all* of the expert witnesses addressed standard of care by emphasizing where Dr. Stockson treated Mr. Jilek. If there were any error in this instruction, it was harmless. MCR 2.613(A).

Before claimed instructional error can be allowed to topple a jury's verdict, appellate courts must be satisfied that the trial court abused its discretion. *Cox v Flint Bd of Hosp Managers*, 467 Mich 1, 8 (2002); *Dawe v Bar-Levav & Assoc, PC,* 289 Mich App 380, __, n 31

[6] Tab C, to Application, the Court of Appeals dissenting opinion, p 2.

(2010). Instructional error warrants reversal only "if the error 'resulted in such unfair prejudice to the complaining party that the failure to vacate the jury verdict would be inconsistent with substantial justice'." *Cox*, *supra* at 8, quoting *Johnson v Corbet*, 423 Mich 304, 327 (1985) and MCR 2.613(A). Even plaintiff's experts emphasized that Dr. Stockson was practicing in urgent care, as they equated her practice in that setting with practicing in an ER. The jury instruction was no violation of *Woodard*; it merely brought the instructions "home" to what was one of the very few undisputed facts of this case. Namely, that Mr. Jilek was seen in urgent care. There was clearly no unfair prejudice to plaintiff.

b. The "morass of irrelevant evidence" plaintiff complains of was evidence about emergency medicine. Defendants were repeatedly thwarted from preventing this. Plaintiff was content with the "morass" and chose not to challenge the family medicine credentials of defense experts. And if something about the trial court's handling of the expert-credentialing issue prejudiced plaintiff, plaintiff needed to ask for a mistrial and not wait to raise the issue only after the verdict.

Plaintiff claims "the circuit court should have stricken the testimony of defendants' experts."[7] But plaintiff *never* moved to strike the defense expert witnesses based on their credentials as family medicine experts.[8] No party is supposed to be able to complain of trial court error when the issue was not argued in time for the trial court to prevent the error. *Napier v Jacobs*, 429 Mich 222, 228 (1987). Defendants presented two family medicine standard of care experts: Dr. Kushner and Dr. Ruoff. Plaintiff *never* challenged Dr. Kushner's qualifications. It is true that "plaintiff's counsel objected to Dr. Ruoff's ability to provide standard of care testimony under MCL 600.2169."[9] But plaintiff never challenged Dr. Ruoff's credentials as a family medicine specialist. While plaintiff was conducing voir dire of Dr. Ruoff, Mr. Davis

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[7] Plaintiff's brief, p 22.
[8] See 6/20/08 hearing transcript. Plaintiff's only motion to strike defense experts was based on a complaint about defendant's answers to plaintiff's interrogatories.
[9] Plaintiff's brief, p 8, citing Vol 6 of 7, pp 88-89.

questioned what percentage of time he spent in urgent care. Lack of urgent care experience, **not** the fact that Dr. Ruoff was a family medicine expert, was the only basis urged for why Dr. Ruoff's testimony should be excluded:

> Q. (Mr. Davis): Your Honor, I don't believe this witness is qualified to testify as to the standard of care in the urgent care center because he only spends ten percent of his time in such a center. And under Michigan law that disqualified him as an expert.
>
> * * *
> (Mr. Davis): * * * If he [Dr. Ruoff] doesn't spend more than fifty percent of his time in the urgent care setting he cannot testify under the—under the law of this state.[10]

But urgent care is not a specialty. Besides, plaintiff's "star" witness—Dr. Sama, board-certified only in emergency medicine and a former EPMG employee who claimed to have once been Dr. Stockson's supervisor[11]--*never* practiced in urgent care.[12] For plaintiff to complain that Dr. Rouff was disqualified because he didn't spend the majority of his time in urgent care is a far different argument from claiming he should have been disqualified because he was only board-certified in family medicine. Our appellate courts are not tolerant of a party urging one basis for an evidentiary objection during trial and a different basis on appeal. *Meagher v Wayne State University,* 222 Mich App 700, 724 (1997) and *Samuel D Begola Services, Inc v Wild Bros*, 210 Mich App 636, 642 (1995).

Plaintiff's brief reports the bare bones of the defense experts' opinions that Dr. Stockson met the standard of care of a family medicine specialist. Then, plaintiff complains that the trial court failed to "compel[] defendants to present experts from" emergency medicine and instead "allowed defendant to present standard of care testimony from physicians in a different area of

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[10] Vol 6 of 7, p 88, 89.
[11] Denial of defendants' motion in limine barred defendants from exploring the "whys" of Dr. Sama's separation from EPMG. 7/30/08, pp 31-35.
[12] Vol 2 of 7 (Sama), pp 172-173.

practice, family medicine."[13] But plaintiff never made this argument in the trial court until *after* the jury returned its verdict. That was too late to matter. An issue that should have been raised during trial, but was not, is not properly preserved for appeal when it was only raised post judgment. *Jones v Porretta*, 428 Mich 132, 158-159 (1987), *Jackson v City of Flint*, 191 Mich App 187, 192 (1991). If the way the trial court handled this issue was prejudicial to plaintiff, the trial court needed to hear that from plaintiff before the jury retired and the verdict was returned.

The reality of this record is that plaintiff had a board-certified family medicine specialist (Dr. Reinhardt) waiting "in the wings." He was deposed pre-trial and testified he believed that Dr. Stockson breached the family medicine standard of care. Plaintiff *chose* not to present him.[14] The reality is that the trial judge informed plaintiff four times before the jury instruction issue was formally argued that his pre-trial Dr. Sama ruling did not preclude defendants from arguing that a family medicine standard of care applied.[15] By the fourth day of trial, the trial judge had *explicitly* informed the parties that he would instruct the jury that family medicine set the standard of care. Defense counsel addressed plaintiff's witness, Dr. Birrer, incorporating the statement that "the standard of practice is what the average family practitioner who is working in an urgent care center would do." Plaintiff's counsel objected. There was colloquy with the court that ended with the trial judge stating "...I do believe that [defense] counsel's statement of what I anticipate the instruction to be would be probably correct."[16] Later, possibly in anticipation of a family medicine jury instruction, plaintiff questioned Dr. Birrer about standard of care in a way

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[13] Plaintiff's brief, p 15.
[14] See discussion at pp 12-13 of defendants' application.
[15] See discussion of transcript on 7/30/08, pp 30-31, Vol 2 of 7, p 33, Vol 4 of 7, pp 73-74 and Vol 6 of 7, p 94, within defendants' application, pp 16-17.
[16] Vol 4 of 7, pp 73-74.

that explicitly blended emergency and family medicine,[17] *both* of which double-boarded Dr. Birrer could testify to.[18]

Plaintiff stuck to the game plan of urging that emergency medicine was the applicable standard of care to assure that Dr. Sama, a former EPMG employee who claimed to have previously supervised Dr. Stockson, would be able to testify that she breached the standard of care. Even with Dr. Reinhardt available to testify as a family medicine expert who thought defendant breached the family medicine standard of care, plaintiff resisted providing the jury with appropriate standard of care testimony. Even during double-boarded Dr. Birrer's testimony, his views that the two standards of care were the same were not prominently featured. The way the trial court's treatment of the expert issue unfolded was not error. The Court of Appeals should have resisted plaintiff's attempt to deploy this appellate parachute.

ARGUMENT II: Exhibits 23, 24 and 27 were irrelevant under MRE 401 because they deal with chest "pain" that Mr. Jilek never said he had. They were also excludable under a century of Michigan cases that say so. And the fact that some of those cases were decided before the MREs were adopted doesn't matter because the cases are propelled by relevancy concerns completely consistent with MRE 401.

a. This is not a situation where an MRE trumps an inconsistent prior common law rule.

The Michigan Rules of Evidence became effective in 1978. That was after *McKernon v Detroit CSR*, 138 Mich 519 (1904) was decided, but not after most of the other Michigan cases on point, including *Buczkowski v May*, 441 Mich 96 (1992), *Zdrojewski v Murphy*, 254 Mich App 50 (2002) and *Gallagher v Det-Macomb Hosp*, 171 Mich App 761 (1988). Plaintiff's contention that this line of cases conflicts with the evidence rules is wrong. At its core, the rule

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[17] Q. "...[W]hat is the standard of care in...emergency medicine *or even family medicine since you've said they're the same*, what does it require of the physician." Vol 4 of 7, p 38.

[18] Dr. Birrer spent the majority of his time in urgent care practice, and if that was family medicine or emergency medicine, he possessed both board certifications. Vol 4 of 7, pp 15, 52.

excluding evidence of a defendant's personally-maintained policies is a relevancy ruling. Since "the standard of physicians and nurses is that they possess and carefully apply such skill and learning as are ordinarily possessed by practitioners in their community," "it [the standard] is not established by internal, administrative rules." *Gallagher* at 768. The panel rejected out-of-state authority, commenting that the "relevancy" of hospital bylaws and regulations was not discussed. *Id.* at 767. Relevant evidence is evidence "having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." MRE 401. "Irrelevant evidence, of course, is inadmissible." *Dacon v Transue*, 441 Mich 315, 339 (1992); MRE 402.

Waknin v Chamberlain, 467 Mich 329 (2002), relied on by plaintiff, is completely inapplicable. In *Wheelock v Eyl,* 393 Mich 74 (1974), before the MREs were adopted, this Court held that a defendant's conviction could not be introduced as substantive evidence of the conduct at issue in a civil case arising out of the same occurrence. In *Waknin,* this Court reexamined that common law rule and analyzed MRE 403, the rule excluding relevant evidence if its probative value is substantially outweighed by the danger of unfair prejudice. The lower courts applied *Wheelock* as an automatic rule of exclusion looking only to "prejudice" and ignoring the MRE requirement of "*unfair*" prejudice. So, "to the extent that *Wheelock* is inconsistent with the subsequently enacted Rules of Evidence, it did not survive their adoption." *Waknin* at 336.

By contrast with *Waknin*, here the exclusionary rule with respect to a defendant's internal policies and guidelines is entirely consistent with the governing relevancy rules.

b. Plaintiff and the Court of Appeals majority ignored the abuse of discretion/MCR 2.613(A) harmless error standard of review that applies.

The three exhibits the Court of Appeals majority decided were admissible all deal with patients who present with complaints of "chest pain."[19] Mr. Jilek never complained of "chest pain." Mr. Jilek came to urgent care complaining about: "continued sinus/respiratory congestion…head and chest congestion…l[eft] ear discomfort…"[20] He continued to catalog cold symptoms when he saw Dr. Stockson, mentioning a "cough," "sputum," "runny nose," "congestions," "sinus pain/drainage," "earache," "headache" and the "trouble breathing" and "chest *tightness*" that "interfere[ed] with his ability to run" were consistent with chest cold patients that family medicine doctors see in their offices every day.[21]

Plaintiff has made no showing of how excluding these three exhibits fell outside the principled range of outcomes so as to be properly characterized as an abuse of discretion. The trial court's ruling comported with the governing case law. There has been no showing of how, even if the ruling was wrong (which it wasn't), it was "inconsistent with substantial justice" so as to leap the considerable "harmless error" hurdle of MCR 2.613(A).

c. Plaintiff's appeal to change the law should be rejected.

"The applicable standard of care is an essential element in a medical malpractice action." *McDougall v Schanz*, 461 Mich 15, 36 (1999). In Michigan, what is required to prove a medical professional breached the standard of care is heavily regulated by our "tort reformed" statutes. In *McDougall* at 35 this Court held that MCL 600.2169 is "an enactment of "substantive law" that must be respected even in the face of this Court's constitutional power to promulgate rules governing practice and procedure. MCL 600.2169's detailed regulation of this issue controls

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[19] Defendants objected to the admissibility of the documents on relevancy grounds. Vol 2 of 7, pp 102, 153.
[20] See defendants' application, p 37 for record cites.
[21] Vol 6 of 7, (Ruoff), p 99.

how standard of care is proven, not a defendant's own policies or procedures. Plaintiff relies heavily on out-of-state cases. This is not the type of issue that should be informed by the law of other jurisdictions. They have their own statutory schemes that differ from Michigan's.

Deviations from (or compliance with) personally-declared policies and procedures do not set the standard of care that prevails in a given medical specialty. The plaintiff Estate admits that.[22] Internal policies also don't *suggest* or "evidence" what the standard of care is. Only a deviation from the standard itself can constitute evidence of negligence. Violations of regulations and ordinances constitute evidence of negligence, see M Civ JI 12.01-12.06, not "violation" of personally-declared policies.

Plaintiff is wrong to urge that it should be able to use a defendant's personally-declared policies "in support of the claim that defendants were professionally negligent."[23] Such policies don't *create* what the standard of care is for a medical specialist. Instead, MCL 600.2169 controls. And such policies don't "evidence" that a defendant breached the applicable standard of care either.

Collins, Einhorn, Farrell & Ulanoff, P.C.

By: Noreen L Slank

NOREEN L. SLANK (P31964)
Attorney for Defendants-Appellants
4000 Town Center, Suite 909
Southfield, MI 48075
(248) 355-4141

Dated: September 28, 2011
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[22] Plaintiff's brief, p 27-28.
[23] Plaintiff's brief, p 28.

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MARK GRANZOTTO (P31492)
Mark Granzotto, P.C.
225 South Troy Street, Ste. 120
Royal Oak, Michigan 48067
248-546-4649
Attorneys for Plaintiff-Appellee

PETER A. DAVIS (P12563)
CAROL A. KUHNKE (P55348)
Davis & Kuhnke, P.C.
405 North Main Street
Ann Arbor, Michigan 48104
734-663-2233
Attorneys for Plaintiff-Appellee

NOREEN L. SLANK (P31964)
Collins Einhorn Farrell & Ulanoff, P.C.
4000 Town Center, Suite 909
Southfield, Michigan 48075
248-355-4141
Attorneys for Defendants-Appellants

CERTIFICATE OF SERVICE

Beverly A. Sutherlin says that on the 28th day of September, 2011, she served a copy of *Defendants-Appellants' Reply Brief Submitted Pursuant to the Court's September 20, 2011 Order* on:

MARK GRANZOTTO (P31492)
Mark Granzotto, P.C.
225 South Troy Street, Ste. 120
Royal Oak, Michigan 48067
Attorneys for Plaintiff-Appellee

PETER A. DAVIS (P12563)
CAROL A. KUHNKE (P55348)
Davis & Kuhnke, P.C.
405 North Main Street
Ann Arbor, Michigan 48104
Attorneys for Plaintiff-Appellee

ALEXANDRA RITUCCI-CHINNI
2813 S. Hiawassee Rd., Ste. 206
Orlando, FL 32835
Attorney for Amicus Curiae American Academy of Urgent Care Medicine

JOANNE GEHA SWANSON (P33594)
Kerr Russell & Weber, PLC
500 Woodward Ave., Ste. 2500
Detroit, MI 48226
Attorney for Amicus Curiae Michigan State Medical Society

MARCY MATSON (P49758)
Hall Matson PLC
1400 Abbot Road, Suite 380
East Lansing, MI 48223
Attorneys for Amicus Curiae Michigan Academy of Family Physicians

RICHARD D. TOTH (P21512)
Sommers Schwartz
2000 Town Center, Ste. 900
Southfield, MI 48075-1100
Attorney for Amicus Curiae Michigan Association for Justice

BETH A. WITTMANN (P63233)
SUSAN HEALY ZITTERMAN (P33392)
Kitch Drutchas Wagner Valitutti & Sherbrook
One Woodward Ave., Ste. 2400
Detroit, MI 48226-3430
Attorneys for Amicus Curiae Michigan Defense Trial Counsel

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Beverly A. Sutherlin